DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 01-20

2. STATE: **ILLINOIS**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE:
October 1, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☒ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT
a. FFY 02 $ 9,614,000
b. FFY 01 $ 7,816,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A Pages127(A),(B),(C), (D), 128,129, 130,131, 131(F)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A Pages127(A),(B),(C), (D), 128,129, 130,131, 131(F)

10. SUBJECT OF AMENDMENT:

INPATIENT

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Not submitted for review by prior approval.

12. SIGNATURE OF AGENCY OFFICIAL: Jackie Garner

13. TYPED NAME: **Jackie Garner**

14. TITLE: **DIRECTOR**

15. DATE SUBMITTED 10-16-01

16. RETURN TO:

ILLINOIS DEPARTMENT OF PUBLIC AID
201 SOUTH GRAND AVENUE, EAST
SPRINGFIELD, IL. 62763-0001
ATTENTION: John Rupcich

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 10/16/01

18. DATE APPROVED: 11/28/01

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL: Kay Daniels

21. TYPED NAME
Cheryl A. Harris

22. TITLE: Associate Regional Administrator
Division of Medicaid and Childrens' Health

23. REMARKS:

RECEIVED
OCT 23 2001
DMCH - IL/IN/OH

FORM HCFA-179 (07-92) *Instructions on Back*

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07/99 C. Direct Hospital Adjustment (DHA) Criteria

1. Qualifying Criteria

Hospitals may qualify for the DHA under this subsection C. under the following categories:

a. Except for hospitals operated by the University of Illinois, children's hospitals, psychiatric hospitals, rehabilitation hospitals and long term stay hospitals, all other hospitals located in Health Service Area (HSA) 6 that either:

i. were eligible for Direct Hospital Adjustments under the CHAP program as of July 1, 1999, and had a Medicaid inpatient utilization rate (MIUR) equal to or greater than the statewide mean in Illinois on July 1, 1999;

ii. were eligible under the Supplemental Critical Hospital Adjustment Payment (SCHAP) program as of July 1, 1999, and had a MIUR equal to or greater than the statewide mean in Illinois on July 1, 1999; or

iii. were county-owned hospitals as defined in 89 Il. Adm. Code148.25(b)(1)(A), and had a MIUR equal to or greater than the statewide mean in Illinois on July 1, 1999.

b. Illinois Hospitals located outside of HSA 6 that have a MIUR greater than 60 percent on July 1, 1999, and an average length of stay less than ten days. The following hospitals are excluded from qualifying from this criteria: children's hospitals; psychiatric hospitals; rehabilitation hospitals; and long term stay hospitals.

c. Children's hospitals, as defined under Section II.C.3, on July 1, 1999.

d. Illinois Teaching hospitals with more than 40 graduate medical education programs, on July 1, 1999, not qualifying in subsections C.1.a., b. or c. above.

e. Except for hospitals operated by the University of Illinois, children's hospitals, psychiatric hospitals, rehabilitation hospitals, long term stay hospitals and hospitals qualifying in subsections (C)(1)(a),(b),(c) or (d) above, all other hospitals located in Illinois that had a MIUR equal to or greater than the mean plus one-half standard deviation on July 1, 1999, and provided more than 15,000 Total days.

10/01 f. Except for hospitals operated by the University of Illinois, children's hospitals, psychiatric hospitals, rehabilitation hospitals, long term stay hospitals and hospitals otherwise qualifying in subsections (C)(1)(a),(b),(c),(d) or (e), all other hospitals that had a combined MIUR greater than 30 percent on July 1, 1999 and provided more than 20,000 total days.

g. Except for hospitals operated by the University of Illinois,

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children's hospitals, psychiatric hospitals, rehabilitation hospitals, long term stay hospitals and hospitals otherwise qualifying in subsections (C)(1)(a),(b),(c),(d),(e)or (f), all other hospitals that had a MIUR greater than 50 percent on July 1, 1999, and provided more than 10,000 total days.

h. Except for hospitals operated by the University of Illinois, children's hospitals, psychiatric hospitals, rehabilitation hospitals, long term stay hospitals and hospitals otherwise qualifying in subsections (C)(1)(a),(b),(c),(d),(e),(f) or (g), all other hospitals that had a MIUR greater than 40 percent on July 1, 1999, and provided more than 7,500 total days and provided obstetrical care as of July 1, 2001.

10/01 D. DHA Rates and Payments

1. For hospitals qualifying under subsection C.1.a. above, the DHA rates are as follows:

a. Hospitals that have a Combined MIUR that is equal to or greater than the Statewide mean Combined MIUR, but less than one standard deviation above the Statewide mean Combined MIUR, will receive $75 per day for hospitals that do not provide obstetrical care and $115 per day for hospitals that do provide obstetrical care.

b. Hospitals that have a Combined MIUR that is equal to or greater than one standard deviation above the Statewide mean Combined MIUR, but less than one and one-half standard deviations above the Statewide mean Combined MIUR, will receive $115 per day for hospitals that do not provide obstetrical care and $155 per day for hospitals that do provide obstetrical care.

c. Hospitals that have a Combined MIUR that is equal to or greater than one and one-half standard deviations above the Statewide mean Combined MIUR, but less than two standard deviations above the Statewide mean Combined MIUR, will receive $135 per day for hospitals that do not provide obstetrical care and $175 per day for hospitals that do provide obstetrical care.

10/01 d. Hospitals that have a Combined MIUR that is equal to or greater than two standard deviations above the Statewide mean Combined MIUR will receive $155 per day for hospitals that do not provide obstetrical care and $195 per day for hospitals that do provide obstetrical care.

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10/01 2. Hospitals qualifying under subsection C.1.a. above, will also receive the following rates:

a. County owned ~~H~~hospitals as defined in Section C.8 of Chapter II, with more than 30,000 Total days will have their rate increased by $455 per day.

b. Hospitals that are not county owned with more than 30,000 total days will have their rate increased by $345 per day.

~~b.~~c. Hospitals with more than 80,000 Total days will have their rate increased by an additional $410 per day.

~~c.~~d. Hospitals with more than 4,500 Obstetrical days will have their rate increased by $110 per day.

~~d.~~e. Hospitals with more than 5,500 Obstetrical days will have their rate increased by an additional ~~$375~~ $185 per day.

~~e.~~f. Hospitals with an MIUR rate greater than 74 percent will have their rate increased by $160 per day.

~~f.~~ g. Hospitals with an average length of stay less than 3.9 days will have their rate increased by $45 per day.

h. Hospitals with a MUIR greater than the statewide mean plus one standard deviation that are designated a Perinatal Level 2 Center and have one or more obstetrical graduate medical education programs as of July 1, 1999, will have their rate increased by $90 per day.

i. Hospitals receiving payments under subsection (D)(1)(b) that have an average length of stay less than 4 days will have their rate increased by $45 per day.

j. Hospitals receiving payments under subsection (c)(2)(A)(ii) that have a MIUR greater than 60 percent will have their rate increased by $220 per day.

k. Hospitals receiving payments under subsection (D)(1)(d) that have a Medicaid inpatient utilization rate greater than 70 percent and have more than 20,000 days will have their rate increased by $5 per day.

3. Hospitals qualifying under subsection C.1.b. above will receive the following rates:

a. Qualifying hospitals will receive a rate of $330 per day.

b. Qualifying hospitals with the more than 1,500 Obstetrical days will have their rate increased by $225 per day.

4. Hospitals qualifying under subsection C.1.c. above will receive the following rates:

a. Hospitals will receive a rate of $30 per day.

b. Hospitals located in Illinois and outside of HSA 6, that have a Medicaid inpatient utilization rate greater than 60 percent, will have their rate increased by $60 per day.

c. Hospitals located in Illinois and inside HSA 6, that have a Medicaid inpatient utilization rate greater than 80 percent, will have their rate increased by ~~$325~~ $430 per day.

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d. Hospitals that are not located in Illinois that have a Medicaid inpatient utilization rate greater than 45 percent will have their rate increased by $35 per day.

e. Hospitals with more than 3,200 Total admissions will have their rate increased by ~~$175~~ $270 per day.

5. Hospitals qualifying under subsection C.1.d. of this Section will receive the following rates:

   a. Hospitals will receive a rate of $45 per day.

   b. Hospitals with a MIUR between 18 percent and 19.75 percent will have their rate increased by an additional $15 per day.

   c. Hospitals with a MIUR equal to or greater than 19.75 percent will have their rate increased by an additional ~~$50~~ $145 per day.

6. Hospitals qualifying under subsection C1.e above will receive ~~$25~~ $205 per day.

7. Hopitals qualifying under subsection C.1.f. of this Section will receive a rate of $65 per day.

8. Hospitals qualifying under subsection C.1.g. of this Section will receive a rate of $45 per day.

9. Hospitals qualifying under subsection C.1.h. of this Section will receive a rate of $60 per day.

~~7.~~10. Hospitals qualifying under subsection C.1.a.iii. above will have their rates multiplied by a factor of two.

~~8.~~11. Payments under this subsection ~~C~~. D will be made at least quarterly, beginning with the quarter ending December 31, 1999.

   a. Payment rates will be multiplied by the Total days.

   b. Total Payment Adjustments

      i. For the CHAP rate period occurring in State fiscal year ~~2000~~2002, total payments will equal the methodologies described above, less the amount the hospital received under DHA ~~and SCHAP~~ for the quarter beginning July 1, ~~1999.~~ 2001. For hospitals not qualifying for ~~CHAP,~~ DHA ~~and SCHAP~~ payments for the quarter ending September 30, ~~1999,~~ 2001, total payments will equal the methodologies described above.

      ii For CHAP rate periods occurring after State fiscal year ~~2000,~~ 2002 total payments will equal the methodologies described above.

      iii. Payments under this subsection ~~C~~ D that are made to disproportionate share hospitals in accordance with Chapter VI.C.7 will be considered to be disproportionate share payments, except for payments made to hospitals as defined in Chapter XIII.

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E. Rural Critical Hospital Adjustment Payments (RCHAP)

Rural Critical Hospital Adjustment Payments (RCHAP) shall be made to ~~certain~~ rural hospitals as defined in Chapter XVI(B(3)) for certain inpatient admissions. The hospital qualifying under this subsection that has the highest number of Medicaid obstetrical care admissions during the CHAP base period shall receive $400,000 per year. The Department shall also make a RCHAP adjustment payment to hospitals qualifying under this subsection at a rate that is the greater of:

1. the product of ~~$745~~ $1490 multiplied by the number of RCHAP Obstetrical Care Admissions in the CHAP base period, or
2. the product of ~~$75~~ $150 multiplied by the number of RCHAP General Care Admissions in the CHAP base period.

F. Each eligible hospital's critical hospital adjustment payment for the CHAP rate period shall equal the sum of the amounts described in A., B., D and E. above. The critical hospital adjustment payments shall be paid to eligible hospitals ~~on a quarterly basis~~ at least quarterly.

~~G. For the month beginning June 1, 1997, and ending June 30, 1997, each hospital which qualifies under Part E., above shall receive an additional payment equal to an annual amount as described under Part E., above. For quarters beginning July 1, 1997, that rate, as described in Part E. above, shall be multiplied by a factor of two.~~

~~H.~~G. Critical Hospital Adjustment Limitations. Hospitals that qualify for trauma center adjustments under Section A. above shall not be eligible for the total trauma center adjustment if, during the CHAP rate period, the hospital is no longer recognized by the Illinois Department of Public Health as a Level I trauma center as required for the adjustment described in A.1. above, or a Level II trauma center as required for the adjustment described in A.2. or A.3. above. In these instances, the adjustments calculated shall be pro-rated, as applicable, based upon the date that such recognition ceased.

~~I. In order to maintian critical hospital access, certain hospitals, excluding municipally licensed children's hospitals, may receive a one-time CHAP payment for the CHAP rate period ending on June 30, 1998, in an amount as defined below:~~

~~1. Hospitals qualifying under either a. or b. below qualify under this Section I.~~
~~a. The hospital was eligible to receive a DHA payment in the July 1, 1996, CHAP rate period, or~~
~~b. The hospital would have been able to receive a DHA payment in the July 1, 1996 CHAP rate period, under subsection C.2.c., if the hospital's base year Medicaid psychiatric and rehabilitation admissions were multiplied by a factor of two.~~

~~2. Hospitals qualifying under number I.1. above shall receive the following payment:~~
~~a. The DHA payment rate from their July 1, 1996 CHAP rate period multiplied by the sum of the following days from the 1995 CHAP base period: Medicaid psychiatric days, medicaid rehabilitation days, and Medicaid obstetrical admissions, less their Medicaid zero-paid days.~~

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H. Critical Hospital Adjustment Payment Definitions

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1. "CHAP base period" means State Fiscal Year 1994, for CHAP payments calculated for the July 1, 1995, CHAP rate period, State Fiscal Year 1995 for CHAP payments calculated for the July 1, 1996, CHAP rate period, etc.
2. "CHAP rate period" means, beginning July 1, 1995, the 12 month period beginning on July 1 of the year and ending June 30 of the following year.
3. "Combined MIUR" means the sum of Medicaid Inpatient Utilization Rate (MIUR) as of July 1, 1999, plus the Medicaid obstetrical inpatient utilization rate, as of July 1, 1999, both of which are defined in Chapter VI.C.8.

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~~4. "Cost Per Day at Eighty Percent Occupancy" means the estimated inpatient cost per day had the hospital been operating at an eighty percent occupancy rate.~~

4. "Medicaid general care admission" means hospital inpatient admissions which were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the Department's paid claims data base, for recipients of medical assistance under Title XIX of the Social Security Act, excluding admissions for normal newborns, Medicare/Medicaid crossover admissions, psychiatric and rehabilitation admissions.
5. "Medicaid Level I rehabilitation admissions" means those claims billed as Level I admissions which were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the Department's paid claims data base, with an occurrence code of 63 when applicable and an ICD-9-CM principal diagnosis code of: 054.3, 310.1 through 310.2, 320.1, 336.0 through 336.9, 344.0 through 344.2, 344.8 through 344.9, 348.1, 801.30, 803.10, 803.84, 806.0 through 806.19, 806.20 through 806.24, 806.26, 806.29 through 806.34, 806.36, 806.4 through 806.5, 851.06, 851.80, 853.05, 854.0 through 854.04, 854.06, 854.1 through 854.14, 854.16, 854.19, 905.0, 907.0, 907.2, 952.0 through 952.09, 952.10 through 952.16, 952.2, and V57.0 through V57.89, excluding admissions for normal newborns.

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6. "Medicaid Level I rehabilitation inpatient day" means the days associated with the claims defined in subsection (~~e~~H)(~~45~~) above.

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7. "Medicaid obstetrical care admission" means hospital inpatient admissions which were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the Department's paid claims data base, for recipients of medical assistance under Title XIX of Social Security Act, with an ICD-9-CM principal diagnosis code of 640.0 through 648.9 with a 5th digit of 1 or 2; 650; 651.0 through 659.9 with a 5th digit of 1, 2, 3, or 4; 660.0 through 669.9 with a 5th digit of 1, 2, 3, or 4; 670.0 through 676.9 with a 5th digit of 1 or 2; or V27 through V27.9; or V30 through V39.9; or any ICD-9-CM principal diagnosis code that is accompanied with a surgery procedure code between 72 and 75.99; and specifically excludes Medicare/Medicaid crossover claims.
8. "Medicaid trauma admission" means those claims billed as admissions which were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the Department's paid claims data base, with an ICD-9-CM principal diagnosis code of: 800.0 through 800.99, 801.0 through 801.99, 802.0 through 802.99, 803.0 through 803.99, 804.0 through 804.99, 805.0 through 805.98, 806.0 through 806.99, 807.0 through 807.69, 808.0 through 808.9, 809.0 through 809.1, 828.0 through 828.1, 839.0 through 839.3, 839.7 through 839.9, 850.0 through 850.9, 851.0 through 851.99, 852.0 through 852.59, 853.0 through 853.19, 854.0 through 854.19, 860.0 through 860.5, 861.0 through 861.32, 862.8, 863.0 through 863.99, 864.0 through 864.19, 865.0 through 865.19, 866.0 through 866.13, 867.0 through 867.9, 868.0 through 868.19, 869.0 through 869.1, 887.0 through 887.7, 896.0 through 896.3, 897.0 through 897.7, 900.0 through 900.9, 902.0 through 904.9, 925, 926.8, 929.0 through 929.99, 958.4, 958.5, 990 through 994.99. For those hospitals recognized as Level I trauma centers solely for pediatric trauma cases, Medicaid trauma admissions are only calculated for the claims billed as admissions, excluding admissions for normal newborns, which were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the Department's paid claims data base, with ICD-9-CM diagnoses within the above ranges for children under the age of 18 excluding admissions for normal newborns.
9. "Medicaid trauma admission percentage" means a fraction, the numerator of which is the hospital's Medicaid trauma admissions and the denominator of which is the total Medicaid trauma admissions in a given 12 month period for all level II urban trauma centers.
~~10. "The CHAP base period" means State Fiscal Year 1995 for RCHAP's calculated for the July 1, 1996, CHAP rate period; State Fiscal Year 1996 for RCHAP's calculated for July 1, 1997, CHAP rate period, etc.~~

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10/99 10. "RCHAP General Care Admission" means Medicaid General Care Admissions, as defined in subsection H.4. above, less RCHAP Obstetrical Care Admissions, occurring in the CHAP base period.

10/99 11. "RCHAP Obstetrical Care Admissions" means Medicaid ~~General~~ Obstetrical Care Admissions, as defined in subsection H.~~4.~~ 7 above, with a Diagnosis Related Group (DRG) of 370 through 375, occurring in the CHAP base period.

10/99 12. "Total admissions" means total paid admissions contained in the Department's paid claims database, including obstetrical admissions multiplied by two and excluding Medicare crossover admissions, for dates of service occurring in State fiscal year 1998 and adjudicated through June 30, 1999.

10/99 13. "Total days" means total paid days contained in the Department's paid claims database, including obstetrical days multiplied by two and excluding Medicare crossover days, for dates of service occurring in State fiscal year 1998 and adjudicated through June 30, 1999.

10/99 14. "Total obstetrical days" means hospital inpatient days for dates of service occurring in State fiscal year 1998 and adjudicated through June 30, 1999, with an ICD-9-CM principal diagnosis code of 640.0 through 648.9 with a 5th digit of 1 or 2; 650; 651.0 through 659.9 with a 5th digit of 1, 2, 3, or 4; 660.0 through 669.9 with a 5th digit of 1, 2, 3, or 4; 670.0 through 676.9 with a 5th digit of 1 or 2; or V27 through V27.9; or V30 through V39.9; or any ICD-9-CM principal diagnosis code that is accompanied with a surgery procedure code between 72 and 75.99; and specifically excludes Medicare/Medicaid crossover claims.

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i. For Delivery or Newborn Care;
ii. Assigned by the Department to a DRG with an assigned weighting factor that is less than 1.0000; or
iii. Billed to the Department under category of service 021 (hospital inpatient psychiatric services) or 022 (hospital inpatient physical rehabilitation services).

c. Children's Hospital Adjustment. A Qualifying Hospital shall receive a payment equal to the product of:
i. The sum Qualified Days from the hospital's Base Period Claims; and
ii. For Illinois hospitals with more than 5,000 Qualified Days, $670; or
iii. For Illinois hospitals with 5,000 or fewer Qualified Days, $300
iv. For out of state hospitals with more than 1,000 Qualified Days, $670; or
v. For out of state hospitals with 1,000 or fewer Qualified Days, $300

5. Primary Care Adjustment - The Department shall make a Primary Care Adjustment to certain hospitals, as defined in this subsection (5).
a. Qualifying Hospital. A hospital located in Illinois that has at least one Qualifying Resident.
b. Qualifying Residents. The number of primary care residents, as reported on form HCFA 2552-96, Worksheet E-3, Part IV, line 1, column 1, for hospital fiscal years ending September 30, 1997, through September 29, 1998.
c. Qualified Admission. For the purposes of this subsection (5), Qualified Admission shall mean a Base Period Claim excluding a claim:
i. Billed to the Department under category of service 021 (hospital inpatient psychiatric services) or 022 (hospital inpatient physical